Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PATIENTS CHOICE FAMILY MEDICINE & REHAB

Respondent Name
AMERICAN FIRE & CASUALTY CO

MFDR Tracking Number
M4-14-1568-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JANURY 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A recent audit of our accounts reflect, a balance on the above patient mentioned. I have received an EOB denial for the above date of service stating **"PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE".** This bill was original submitted by mail on 6/28/2013, spoke with adjuster Sharon Douglas on 09/03/2013 to check the payment status that's when she stated that she was unable to find the claim so I was told by the adjuster to rebill and resubmit the claim, the claim was resubmitted on 9/03/2013, on 09/23/2013 I received a denial for procedure code (99204) denying the procedure code for above reason, a request for reconsideration was mailed on 10/22/2013 with an appeal letter explaining that we did meet the level 4 requirements and requesting for our claim to be process for payment. On 11/18/2013 I received another denial stating that this is [sic] claim was a duplicate despite the fact that it was stamped request for reconsideration, on 11/21/2013 I received another denial stating that the payer deems the information submitted does not support this level of service. Our office feels that this doctor's visit meets the level 4 requirements and we have submitted all documentation needed to process our claim for payment."

Amount in Dispute: $368.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on February 4, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 20, 2013	CPT Code 99204	$368.43	$271.13

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. [Add any rules that are pertinent to or cited in the body of your decision, with a brief description (you don't have to quote the text of the rule here, just describe what the rule is about).]
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – (150) Payer deems the information submitted does not support this level of service.
   - 2 – (W1) Workers Compensation State Fee Schedule Adjustment.
   - 1 – CV: The level of E & M Code submitted is not supported by documentation.
   - 2 – The amount paid reflects a fee schedule reduction.
   - 3 – The charge for this procedure exceeds the fee schedule allowance.
   - 1 – (18) Duplicate claim/service.

Issues

1. Did the requestor support the level of service for the procedure billed?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99204 is:

   > Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

   The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

   - Documentation of the Comprehensive History
     - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic conditions. Documentation found listed four chronic conditions, thus meeting this component.
     - Review of Systems (ROS) requires ten or more systems or the pertinent positive and/or negatives of some systems with a statement, "all other negative". Documentation found listed five systems with the ROS checked on "All Other Neg", this component was met.
     - Past Family, and/or Social History (PFSH) requires a complete (two or three) history areas to be documented. The documentation found listed three areas. This component was met.
   - Documentation of a Comprehensive Examination:
     - Requires a general multi-system exam (eight or more systems) to be documented. The documentation found listed eight body/organ systems: head, chest, neck, constitutional, eyes, eyes/nose/throat (ENT), respiratory, cardiovascular. This component was met.

   The division concludes that the documentation sufficiently supports the level of service billed.

2. The For the reasons stated above, the services in dispute are eligible for payment pursuant to 28 TAC §134.203 (c) as follows: (54.30 / 34.023)*$166.81 = $271.13

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $271.13.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $271.13 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 30, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.